Certificate of Need Application Instructions

Please respond to every question unless directed to do otherwise. When you have completed the application, submit **3 copies** of the completed application* to the Office of Health Systems Development, Rhode Island Department of Health, 3 Capitol Hill, Room 407, Providence, Rhode Island 02908. Upon submission, the application will be reviewed for acceptability, and within ten (10) working days the applicant will be notified of any deficiencies if the application has been found not acceptable in form. Applications found substantially deficient may not be reviewed in the current cycle. Thus, a complete response to every question in this application and its relevant appendices may save valuable time.

This application should be completed only after a thorough review of Chapter 15, Title 23, of the General Laws of Rhode Island 1956, as amended, and the Rules and Regulations for Determination of Need for New Health Care Equipment and New Institutional Health Services (R23-15 CON). The Rules and Regulations can be found on the Internet at http://www.rules.state.ri.us/rules/released/pdf/DOH/DOH_155_.pdf

Several questions in this application form and its appendices require the use of additional sheets of paper. On separate sheets of paper, please identify the application questions to which they apply, and please attach the separate sheets of paper either to the page in the application on which the question appears or at the end of the application under an individual tab. Each separate answer sheet to a question should be numbered with the number of the question from the application plus a consecutive lower case letter. Please indicate 'N/A' next to any question that does not pertain to the proposal. Included with this application form are several appendices. Please complete those appendices which are applicable to your proposal and include them with the application.

The application must be submitted in a softbound format to facilitate the mailing of the application to the members of the Health Services Council.

Once the application is deemed acceptable for review, **25 copies** of the completed application including all the satisfied deficient materials must be submitted to the Office of Health Systems Development prior to the date of review initiation.

All questions concerning this application should be directed to the Office of Health Systems Development at (401) 222-2788.

*Applicants need not copy this page nor appendices not applicable to this proposal.

Rhode Island Department of Health
Office of Health Systems Development
3 Capitol Hill, Room 407
Providence, Rhode Island 02908

Certificate of Need Application Fee Instructions

Any applicant proposing to file a certificate of need (CON) proposal must include an application fee at the time of submission.

Pursuant to section 23-15-10 RIGL, the application fee requirements are as follows*:

1) Applicants shall submit an application fee prior to requesting any CON review of matters pursuant to the requirements of this chapter; except that health care facilities owned and operated by the State of Rhode Island shall be exempt from this application fee.

2) The application fee shall be paid by check and made payable to the **Rhode Island General Treasurer**

3) For expeditious review proposals, the applicant shall include an application fee of $750 per application **plus** an amount equal to one third of one percent (.33%) of the total capital expenditure costs associated with the application.

4) For all other proposals, the applicant shall submit an application fee of $500 per application **plus** an amount equal to one third of one percent (.33%) of the total capital expenditure costs associated with the application.

5) Application fees for applications accepted for review shall be non-refundable. Should your application be deemed unacceptable for review, the check for the application fee will be returned.

All questions concerning this application should be directed to the Office of Health Systems Development at (401) 222-2788.

*Applicants need not copy this page nor appendices not applicable to this proposal.

Rhode Island Department of Health
Office of Health Systems Development
3 Capitol Hill, Room 407
Providence, Rhode Island 02908

Certificate of Need Application

(April 2005)

Name of Applicant: _____

Title of Application: _____

Date Application Submitted: _____

Amount of Fee: _____

Pursuant to Chapter 15, Title 23 of The General Laws of Rhode Island, 1956, as amended, and Rules and Regulations for Determination of Need for New Health Care Equipment and New Institutional Health Services (R 23-15- CON)

All questions concerning this application should be directed to the Office of Health Systems Development at (401) 222-2788.

Please have the appropriate individual attest to the following:

"I hereby certify that the information contained in this application is complete, accurate and true."

_____

signed and dated by the President or Chief Executive Officer

Rhode Island Department of Health
Office of Health Systems Development
3 Capitol Hill, Room 407
Providence, Rhode Island 02908

Certificate of Need Application

1.) Date Submitted: _____

2.) Brief Descriptive Title of Proposal: _____

_____

3.) Brief Summary Description of Proposal (Please confine your summary to the space provided. For a longer description of your proposal, refer to Question 30): _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

4.) Capital Cost of Proposal (from response to Questions 41 and 42): _____

5.) Operating Cost of Proposal (first full year after implementation, from response to Question 49): _____

6.) Month and year the proposal would be implemented (i.e. services first offered assuming approval): _____

7.) Name and address of Applicant, including zip code: _____

_____

_____

8.) Name and address of facility (if different from applicant): _____

_____

_____

9.) Name, address, telephone, e-mail and fax number of Chief Executive Officer: _____

_____

_____

10.) Name, title, address, telephone, e-mail and fax number of person to contact regarding this application: _____

_____

11.) Facility license number: _____ Medicare provider number: _____

12.) Are you requesting an "expeditious review" for this application? Yes____ No____

- If the response to Question 12 is 'Yes', please complete Appendix A

13.) Are you requesting an "accelerated review" for this application? Yes____ No____

- If the response to Question 13 is 'Yes', please provide a brief justification for the accelerated review.

14.) List all officers, members of the board of directors, trustees, stockholders, partners and other individuals who have an equity or otherwise controlling interest in the applicant. For each individual, provide their home and business address, principal occupation, position with respect to the applicant, and amount, if any, of the percentage of stock, share of partnership, or other equity interest that they hold.

15.) For each individual listed in response to Question 14, list all (if any) other health care facilities or entities within or outside Rhode Island in which he or she is an officer, director, trustee, shareholder, partner, or in which he or she owns any equity or otherwise controlling interest. For each individual, please identify: A) the relationship to the facility and amount of interest held, B) the type of facility license held (e.g. nursing facility, etc.), C) the address of the facility, D) the state license #, E) Medicare provider #, and F) any professional accreditation (e.g. JACHO, CHAP, etc.).

16.) If any individual listed in response to Question 14, has any business relationship with the applicant, including but not limited to: supply company, mortgage company, or other lending institution, insurance or professional services, please identify each such individual and the nature of each relationship.

17.) Have any individuals listed in response to Question 14 been convicted of any state or federal criminal violation within the past 20 years? Yes___ No___.

- If response to Question 17 is 'Yes', please identify each person involved, the date and nature of each offense and the legal outcome of each incident.

18.) Please provide organization chart for the applicant, identifying all "parent" entities with direct or indirect ownership in or control of the applicant, all "sister" legal entities also owned or controlled by the parent(s), and all subsidiary entities owned by the applicant. Please provide a brief narrative clearly explaining the relationship of these entities, the percent ownership the principals have in each (if applicable), and the role of each and every legal entity that will have control over the applicant.

19.) Please list all licensed healthcare facilities (in Rhode Island or elsewhere) owned, operated or controlled by any of the entities identified in response to Question 18 (applicant and/or its principals). For each facility, please identify: A) the entity, applicant or principal involved, B) the type of facility license held (e.g. nursing facility, etc.), C) the address of the facility, D) the state license #, E) Medicare provider #, and F) any professional accreditation (e.g. JACHO, CHAP, etc.).

20.) Have any of the facilities identified in Question 19 had: A) federal conditions of participation out of compliance, B) decertification actions, or C) any actions towards revocation of any state license?
Yes ___ No ___

- If response to Question 20 is 'Yes', please identify the facility involved, the nature of each incident, and the resolution of each incident.

21.) Have any of the facilities owned, operated or managed by the applicant and/or any of the entities identified in Question 19 during the last 5-years had bankruptcies and/or were placed in receiverships? Yes___ No___

- If response to Question 21 is 'Yes', please identify the facility and its current status.

22.) If the applicant is a partnership, please attach a copy of the Certificate of Partnership and the Partnership Agreement. If the applicant is a corporation, please attach a copy of the Certificate of Incorporation, the Articles of Incorporation and the By Laws. If the applicant is a limited liability company, please attach a copy of the Certificate of Organization, the Articles of Organization and the Operating Agreement.

23.) Please place an 'X' next to each category that best describes the facility named in Question 8.

___ Hospital
___ Nursing facility
___ Inpatient rehabilitation center (including drug/alcohol treatment centers)
___ Freestanding ambulatory surgical center
___ Inpatient hospice
___ Other (specify) _____

24.) Please place an 'X' next to the category that best describes the ownership of the facility.

___ non-profit ___for-profit

25.) Please check each and every category that describes this proposal. Note: If your proposal does not fit any of these categories, a certificate of need may not be required.

A. ___ construction, development or establishment of a new healthcare facility
B. ___ a capital expenditure for
   1. ___ health care equipment in excess of $1,000,000
   2. ___ construction or renovation of a health care facility in excess of $2,000,000
   3. ___ an acquisition by or on behalf of a health care facility or HMO by lease or donation
   4. ___ acquisition of an existing health care facility, if a notice of intent has not been filed with the state agency, or if the services or the bed capacity of the facility will be changed
C. ___ any capital expenditure which results in an increase in bed capacity of a hospital and inpatient rehabilitation centers (including drug and/or alcohol abuse treatment centers).
D. ___ any capital expenditure which results in an increase in bed capacity of a nursing facility in excess of 10 beds or 10% of facility's licensed bed capacity, which ever is greater.
E. ___ the offering of a new health service with annualized costs in excess of $750,000
F. ___ predevelopment activities not part of a proposal, but which cost in excess of $2,000,000
G. ___ establishment of an additional inpatient premise of an existing inpatient health care facility
H. ___ tertiary or specialty care services

26.) Does this proposal involve the provision of health services to inpatients? Yes____ No____

- If the response to Question 26 is 'Yes', please complete Appendix B

27.) Is the applicant a nursing facility, or does this proposal involve a nursing facility? Yes____ No____

- If the response to Question 27 is 'Yes', please complete Appendix C.

28.) Does this proposal involve any construction or renovation? Yes____ No____

- If the response to Question 28 is 'Yes', please complete Appendix D.

29.) Does any portion of the capital expenditure for fixed and moveable equipment contained within this proposal comprise the purchase of an individual piece of health care equipment at a cost of $1,000,000 or more? Yes____ No____

- If the response to Question 29 is 'Yes', please complete Appendix E for each such piece of equipment.

30.) On a separate sheet of paper, please discuss the proposal and present the demonstration of the public need for this proposal. Description of the public need must include at least the following elements:

A. Identify the cities and towns that comprise the primary and secondary service area of the facility. Identify the size of the population to be served by this proposal and (if applicable) the projected changes in the size of this population.

B. Identify the health needs of this population relative to this proposal.

C. Describe the availability and accessibility of other existing facilities, equipment and services in the state capable of meeting the health needs identified in (B) above for the population identified in (A) above either in whole or in part.

D. Total throughput possible and utilization data (for the past three years and as projected through the next three years after implementation) as a number and a percentage of throughput for each separate area of service affected by this proposal.

E. Identify what portion of the need for the services proposed in this project is not currently being satisfied, and what portion of that unmet need would be satisfied by approval and implementation of this proposal.

F. Identify and evaluate alternative proposals to satisfy the unmet need identified in (E) above.

G. Provide a justification for the instant proposal and the scope thereof as opposed to the alternative proposals identified in (F) above.

31.) In the case of an application from a hospital, please discuss the potential impact and effectiveness of the proposal in responding to public health emergencies.

32.) Please identify any recognized health disparities of the population in the applicant's service area and discuss the potential impact of the proposal on reducing and/or eliminating health disparities of the population in the applicant's service area.

33.) If this proposal involves a new health service, discuss whether your facility and other facilities in your service area have documented conditions of overcrowding or excessive waiting times in programs identical or similar to the one proposed herein. Provide all appropriate documentation to substantiate your response.

34.) On a separate sheet of paper, please comment on the efficacy (i.e., the demonstrable effect on health status) of the new institutional health service and/or new health care equipment proposed herein. These comments must include reference to appropriate published reports of epidemiological or clinical studies as they may pertain to the proposed health service and/or new health care equipment, where applicable.

35.) Please discuss the performance of the applicant regarding provision of uncompensated care, community services or access by minorities and handicapped persons to programs receiving federal financial assistance, including the existence of any civil rights access complaints against the applicant.

36.) Please discuss actions taken by this facility in the past to remove transportation, design, and financial barriers that limit access to the facility.

37.) Please discuss the extent to which low income persons, racial and ethnic minorities, women, handicapped persons, and the elderly presently have access to such services and the extent to which such groups are likely to have access to this service.

38.) In cases where a reduction, termination, interruption, or relocation of a service is contemplated, please discuss plans for accommodating the needs of the population, including low-income persons, racial and ethnic minorities, women, handicapped persons and the elderly.

39.) Please discuss the extent to which Title XVIII (Medicare), Title XIX (Medicaid) and medically indigent patients are served by the applicant.

40.) Please discuss the extent to which the applicant offers a range of means by which a person will have access to its services (e.g., outpatient services, admission by house staff, admission by personal physician).

41.) A) Please itemize the capital costs of this proposal. Present all amounts in thousands (e.g., $112,527=$113). If the proposal is going to be implemented in phases, identify capital costs by each phase.

CAPITAL EXPENDITURES		
	Amount	**Percent of Total**
Survey/Studies	$	%
Fees/Permits	$	%
Architect	$	%
"Soft" Construction Costs	$	%
Site Preparation	$	%
Demolition	$	%
Renovation	$	%
New Construction	$	%
Contingency	$	%
"Hard" Construction Costs	$	%
Furnishings	$	%
Movable Equipment	$	%
Fixed Equipment	$	%
"Equipment" Costs	$	%
Capitalized Interest	$	%
Bond Costs/Insurance	$	%
Debt Services Reserve[1]	$	%
Accounting/Legal	$	%
Financing Fees	$	%
"Financing" Costs	$	%
Land	$	%
Other (specify _____)	$	%
"Other" Costs	$	%
TOTAL CAPITAL COSTS	**$**	**100%**

[1] Should not exceed the first full year's annual debt payment.

B.) Given the above projection of the total capital expenditure of the proposal, please provide an analysis of this proposed cost. This analysis must address the following considerations:

1. The financial plan for acquiring the necessary funds for all capital and operating expenses and income associated with the full implementation of this proposal, for the period of 6 months prior to, during and for three (3) years after this proposal is fully implemented, assuming approval.

2. The relationship of the cost of this proposal to the total value of your facility's physical plant, equipment and health care services for capital and operating costs.

3. A forecast for inflation of the estimated total capital cost of the proposal for the time period between initial submission of the application and full implementation of the proposal, assuming approval, including an assessment of how such inflation would impact the implementation of this proposal.

42.) Please indicate the financing mix for the capital cost of this proposal. **NOTE:** the Health Services Council's policy requires a minimum 20 percent equity investment in CON projects (33 percent equity minimum for equipment-related proposals).

Source	Amount	Percent	Interest Rate	Terms (Yrs.)
Equity*	$	%		
Debt**	$	%	%	
Lease**	$	%	%	
TOTAL	**$**	**100%**		

* Equity means non-debt funds contributed towards the capital cost of an acquisition or project which are free and clear of any repayment obligation or liens against assets, and that result in a like reduction in the portion of the capital cost that is required to be financed or mortgaged (R23-15-CON).

** If debt and/or lease financing is indicated, please complete Appendix F.

43.) Please identify the specific source(s) and evidence of commitment of equity identified in the response to Question 42.

44.) Will a fundraising drive be conducted to help finance this approval? Yes____ No____

45.) Will a feasibility study be conducted of fundraising potential? Yes___ No___

- If the response to Question 45 is 'Yes', please provide a copy of the feasibility study.

46.) Will the applicant apply for state and/or federal capital funding? Yes___ No ___

- If the response to Question 46 is 'Yes', please provide the source: _____, amount: _____, and the expected date of receipt of those monies: _____.

47.) Please calculate the yearly amount of depreciation and amortization to be expensed.

Depreciation/Amortization Schedule - Straight Line Method					
	Improvements	Equipment		Amortization	Total
		Fixed	Movable		
Total Cost	$	$	$	$	$ *1*
(-) Salvage Value	$	$	$	$	$
(=) Amount Expensed	$	$	$	$	$
(/) Average Life (Yrs.)					
(=) Annual Depreciation	**$**	**$**	**$**	**$**	**$ *2***

1 Must equal the total capital cost (Question 42 above) less the cost of land and less the cost of any assets to be acquired through lease financing

2 Must equal the incremental "depreciation/amortization" expense, column -5-, in Question 49 (below).

48.) For the first full operating year of the proposal (identified in Question 49 below), please identify the total number of FTEs (full time equivalents) and the associated payroll expense (including fringe benefits) required to staff this proposal. Please follow all instructions and present the payroll in thousands (e.g., $42,575=$43). Please describe the plan for the recruitment and training of personnel (if applicable).

	EXISTING		ADDITIONS/(REDUCTIONS)		NEW TOTALS	
PERSONELL	Number of FTEs	Payroll W/Fringes	Number of FTEs	Payroll W/Fringes	Number of FTEs	Payroll W/Fringes
Medical Director		$		$		$
Physicians		$		$		$
Administrator		$		$		$
RNs		$		$		$
LPNs		$		$		$
Nursing Aides		$		$		$
PTs		$		$		$
OTs		$		$		$
Speech Therapists		$		$		$
Clerical		$		$		$
Housekeeping		$		$		$
Other: (specify_____)		$		$		$
Other: (specify_____)		$		$		$
Other: (specify_____)		$		$		$
TOTAL		**$**		**$ *1***		**$**

1 Must equal the incremental "payroll w/fringes" expense in column -5-, Question 49 (below).

INSTRUCTIONS:

"FTEs" Full time equivalents, are the equivalent of one employee working full time (i.e., 2,080 hours per year)
"Additions" are NEW hires;
"Reductions" are staffing economies achieved though attrition, layoffs, etc. It does **NOT** report the reallocation of personnel to other departments.

49.) Please complete the following pro-forma income statement for each unit of service. Present all dollar amounts in thousands (e.g., $112,527=$113). Be certain that the information is accurate and supported by other tables in this worksheet (i.e., "depreciation" from Question 47 above, "payroll" from Question 48 above). If this proposal involved more than two separate "units of service" (e.g., pt. days, CT scans, outpatient visits, etc.), insert additional units as required.

PRO-FORMA P & L STATEMENT FOR WHOLE FACILITY					
	ACTUAL PREVIOUS YEAR 20__ (1)	**BUDGETED CURRENT YEAR 20__ (2)**	**<-- FIRST FULL OPERATING YEAR 20__ -->**		
			CON DENIED (3)	**CON APPROVED (4)**	**INCREMENTAL DIFFERENCE *1* (5)**
REVENUES:					
Net Patient Revenue	$	$	$	$	$ *2*
Other:	$	$	$	$	$
Total Revenue	$	$	$	$	$
EXPENSES:	$	$	$	$	$
Payroll w/Fringes	$	$	$	$	$ *3*
Bad Debt	$	$	$	$	$ *4*
Supplies	$	$	$	$	$
Office Expenses	$	$	$	$	$
Utilities	$	$	$	$	$
Insurance	$	$	$	$	$
Interest	$	$	$	$	$ *5*
Depreciation/Amortization	$	$	$	$	$ *6*
Leasehold Expenses	$	$	$	$	$
Other: (specify _____)	$	$	$	$	$
Other: (specify _____)	$	$	$	$	$
Total Expenses	$	$	$	$	$ *7*
OPERATING PROFIT:	$	$	$	$	$

For each service to be affected by this proposal, please identify each service and provide: the utilization, average net revenue per unit of services and the average expense per unit of service.

Service (#s):					
Net Revenue Per Unit *8*	$	$	$	$	$
Expense Per Unit	$	$	$	$	$
Service (#s):					
Net Revenue Per Unit *8*	$	$	$	$	$
Expense Per Unit	$	$	$	$	$

INSTRUCTIONS: Present all dollar amounts (except unit revenue and expense) in thousands.

1 The Incremental Difference (column -5-) represents the actual revenue and expenses associated with this CON. It does not include any already incurred allocated or overhead expenses. It is column -4- less column –3-.
2 Net Patient Revenue (column -5-) equals the different units of service times their respective unit reimbursement.
3 Payroll with fringe benefits (column -5-) equals that identified in Question 48 above.
4 Bad Debt is the same as that identified in column -4-, Question 50 below.
5 Interest Expense equals the first full year's interest paid on debt.
6 Depreciation equals a full year's depreciation (Question 47 above), not the half year booked in the year of purchase.
7 Total Expense (column -5-) equals the operating expense of this proposal and is defined as the sum of the different units of service;
8 Net Revenue per unit (of service) is the actual average net reimbursement received from providing each unit of service; it is NOT the charge for that service.

50.) Provide an analysis and description of the impact of the proposed new institutional health service or new health equipment, if approved, on the charges and anticipated reimbursements in any and all affected areas of the facility. Include in this analysis consideration of such impacts on individual units of service and on an aggregate basis by individual class of payer. Such description should include, at a minimum, the projected charge and reimbursement information requested above for the first full year after implementation, by payor source, and shall present alternate projections assuming (a) the proposal is not approved, and (b) the proposal is approved. If no additional (incremental) utilization is projected, please indicate this and complete this table reflecting the total utilization of the facility in the first full fiscal year.

PROJECTED PAYOR MIX OF SERVICE(S) AND NET REVENUE - FIRST FULL OPERATING YEAR 20 __, IF IMPLEMENTED.						
Unit of Service	**Payor**	**Projected Utilization**		**Net Revenue Per Unit of Service**	**Total Net Patient Revenue**	**Bad Debt *1***
Identify Service *2*	Medicare	#	%	$	$	$
	Medicaid	#	%	$	$	$
	Blue Cross	#	%	$	$	$
	Commercial	#	%	$	$	$
	HMO's	#	%	$	$	$
	Self Pay	#	%	$	$	$
	Charity/Free Care	#	%	$0	$0	$0
	Other: (specify _____)	#	%	$	$	$
	SUB-TOTAL	**#**	**100%**	**$ *3***	**$**	**$**
	SUB-TOTAL			**Average**	**Total**	**Total**

NOT IMPLEMENTED

Unit of Service	**Payor**	**Projected Utilization**		**Net Revenue Per Unit of Service**	**Total Net Patient Revenue**	**Bad Debt *1***
Identify Service *2*	Medicare	#	%	$	$	$
	Medicaid	#	%	$	$	$
	Blue Cross	#	%	$	$	$
	Commercial	#	%	$	$	$
	HMO's	#	%	$	$	$
	Self Pay	#	%	$	$	$
	Charity/Free Care	#	%	$0	$0	$0
	Other: (specify _____)	#	%	$	$	$
	SUB-TOTAL	**#**	**100%**	**$ *3***	**$**	**$**
	SUB-TOTAL			**Average**	**Total**	**Total**

DIFFERENCE

Unit of Service	Payor	Projected Utilization		Net Revenue Per Unit of Service	Total Net Patient Revenue	Bad Debt *1*
Identify Service *2*	Medicare	#	%	$	$	$
	Medicaid	#	%	$	$	$
	Blue Cross	#	%	$	$	$
	Commercial	#	%	$	$	$
	HMO's	#	%	$	$	$
	Self Pay	#	%	$	$	$
	Charity/Free Care	#	%	$0	$0	$0
	Other: (specify _____)	#	%	$	$	$
	SUB-TOTAL	**#**	**100%**	**$ *3***	**$**	**$**
	SUB-TOTAL			**Average**	**Total**	**Total**
	**TOTAL ALL ----------> **				**$ *4***	**$ *5***

INSTRUCTIONS:

This table itemizes the Net Patient Revenue and Bad Debt identified in column -5-, Question 49 (above). If more than two units of service are affected by this proposal, please copy this table and submit additional forms as necessary. Please round all amounts to the nearest dollar (e.g., $59.44=$59).

1 Bad Debt varies by payor source and may vary across services; it does NOT include free care.
2 Services (e.g., pt. days, ER visits, surgeries, etc.) are the same as identified in the bottom portion of Question 49 above).
3 The average net revenue per unit of service is the same as reported in the bottom half of Question 49 (above).
4 Total net Revenue equals the net patient revenue identified in column -5- of Question 49 (above).
5 Total bad debt equals the bad debt reported in column -5- of Question 49 (above).

51.) Please provide the following financial information:

A. The total amount of debt currently held by the applicant, broken down into short term debt (debt which will be fully repaid within one year of the date of the filing of this application), and long term debt (debt which will take longer than one year to repay), exclusive of any debt associated with the financing of this proposal.

B. The terms and conditions of any agreements entered into by the Applicant and any lender (such as conditions that may be entered into under bond covenants or bank loans) prior to the filing of this application, which may deter the applicant from obtaining any additional debt.

C. Audited financial statements for the previous fiscal year and unaudited financial statements for the current fiscal year-to-date.

D. Please complete the following table for the previous three fiscal years and year to date:

Year	Total Endowment	Restricted	Unrestricted
	$	$	$
	$	$	$
	$	$	$
Year to Date __ /___/___	$	$	$

E. Please discuss the impact of approval or denial of the proposal on the future viability of the applicant and of the providers of health services to a significant proportion of the population served or proposed to be served by the applicant.

52.) **A) If the applicant is an existing facility:**

Please identify and describe any outstanding cited health care facility licensure or certification deficiencies, citations or accreditation problems as may have been cited by appropriate authority. Please describe when and in what manner this licensure deficiency, citation or accreditation problem will be corrected.

B) If the applicant is a proposed new health care facility:

Please describe the quality assurance programs and/or activities which will relate to this proposal including both inter and intra-facility programs and/or activities and patient health outcomes analysis whether mandated by state or federal government or voluntarily assumed. In the absence of such programs and/or activities, please provide a full explanation of the reasons for such absence.

C) If this proposal involves construction or renovation:

Please describe your facility's plan for any temporary move of a facility or service necessitated by the proposed construction or renovation. Please describe your plans for ensuring, to the extent possible, continuation of services while the construction and renovation take place. Please include in this description your facility's plan for ensuring that patients will be protected from the noise, dust, etc. of construction.

53.) Please identify what other areas of service, if any, would be likely to require development at some time as a direct result of this proposal? Please specify what consequent capital, operating and equipment costs might be expected related to the other areas of service, the date of the additional project undertaking and the date of the additional project completion.

54.) Please complete the following table by identifying all the Certificate of Need and Change Order Requests granted to the applicant for the last five years:

Year Approved	Project Description	Capital Cost of the Project ($M)	Debt Financing ($M)	Equity Financing ($M)	Start Date*	Date of Completion*
	TOTAL					

* Please identify whether each date is actual or proposed.

55.) Please discuss the relationship of the proposal to any long-range capital improvement plan of the applicant.

56.) If this facility admits inpatients, please discuss the extent to which the physicians privileged to admit patients to this facility have offices in designated poverty areas or practice at neighborhood health centers.

57.) Please discuss the impact of the proposal on the community to be served and the people of the neighborhoods close to the health care facility who are impacted by the proposal.

58.) Please discuss the impact of the proposal on the quality of health care in the state and in the population area to be served by the applicant.

59.) Please discuss the relationship of this proposal to any state health plans that may have been formulated by the state agency and are relevant to the proposal.

60.) Please discuss the relationship of the services proposed to be provided to the existing health care system of the state

61.) Please identify the derivable operating efficiencies, if any, (i.e., economies of scale or substitution of capital for personnel) which may result in lower total or unit costs as a result of this proposal.

62.) Please discuss the efficiency and appropriateness of the proposed new institutional health services, including the extent to which the proposed new service or equipment, if implemented, will not result in any unnecessary duplication of existing services or equipment.

63.) Please comment on the affordability of the proposal at the time, place and under the circumstances proposed, considering, as applicable, the definition of affordability provided in the Rules and Regulations for Determination of Need for New Health Care Equipment and New Institutional Health Services (R23-15-CON, Section 3.26) as follows: "**Affordability"** means the relative ability of the people of the state to pay for or incur the cost of a proposal, given:

A. consideration of the state's economy;

B. consideration of the statements of authorities and/or parties affected by such proposals;

C. economic, financial, and/or budgetary constraints of parties affected by such proposals, including cost impact statements submitted by the State Medicaid Agency or State Budget Officer;

64.) Please complete the following tables with data from the previous fiscal year.

Unit of Service by Patient's Primary Source of Payment

Primary Source Of Payment	**Number of Inpatient Discharges**	**Number of Outpatient Visits**	**Number of Inpatient Days**
Medicare Title XVIII			
Medicaid Title XIX			
Blue Cross			
Commercial			
HMO's			
Self Pay			
Charity/Free Care			
Other: (specify _____)			
TOTAL			

65.) Please identify and describe any existing or proposed programs for achieving continuity of patient care as it may pertain to this proposal. Please specifically address the following:

A. Any existing or proposed programs for service linkages with other health care facilities or providers pertaining to the proposed new institutional health service. Please include in the description an identification of the other health care facilities with whom linkages are proposed and a description of the type of linkages sought.

B. The relationship of this proposal to other programs and services (current or proposed) at your facility and how the instant proposal will enhance the continuity of care at your facility.

66.) Please identify any arrangements between the applicant and any medical schools and/or academic medical centers and describe the relationship of the proposal to such entities.

67.) Please describe on a separate sheet of paper all energy considerations incorporated in this proposal.

68.) Please comment on any other factors, which the applicant thinks should be considered prior to a decision by the state agency.

Appendix A

Request for Expeditious Review

1.) Name of applicant: _____

2.) Indicate why an expeditious review of this application is being requested by marking at least one of the following with an 'X'.

_____a. for emergency needs documented in writing by the State Fire Marshal or other cognizant authority
_____b. for the purpose of alleviating fire and/or safety hazards certified by the State Fire Marshal or other cognizant authority as adversely affecting the life and health of patients or staff
_____c. for correcting conditions which have been identified by the appropriate voluntary accrediting agency as militating against provision of an adequate standard of care
_____d. for a public health urgency to be determined by the Health Services Council.

3.) For each response with an 'X' beside it in Question 2 above, furnish documentation as indicated:

2.a: a written communication from the State Fire Marshal or other cognizant authority setting forth the particular energy needs cited and the measures required to meet the emergency;
2.b: documentation from the State Fire Marshal or other cognizant authority stating that particular fire and/or safety hazards currently exist which adversely affect the life and health of patients or staff and outlining the measures which must be taken in order to alleviate these hazards;
2.c: a written communication from the accrediting agency naming specific deficiencies and required remedies for situations which militate against the provision of an adequate standard of care;
2.d: a complete description and documentation of the public health urgency, which, in the applicant's opinion, necessitates an expeditious review.

Appendix B

Special Questions for Certificate Of Need Applications Involving the Provision of Services to Inpatients

All certificate of need applications, which involve the provision of services to inpatients, must be accompanied by responses to the questions posed herein.

Name of applicant: _____

1. Are there programmatic alternatives to the provision of new institutional health services to inpatients as proposed herein which are superior in terms of:

   a. cost ___ Yes ___ No
   b. efficiency ___ Yes ___ No
   c. appropriateness ___ Yes ___ No

2. For each No response in Question 1, discuss your finding that there are no programmatic alternatives superior to this proposal.

3. For each Yes response in Question 1, identify the superior programmatic alternative to this proposal, and explain why that superior alternative was rejected in favor of this proposal.

4. In the absence of provision to inpatients of the new institutional health services proposed herein, will patients encounter serious problems in obtaining care of the type proposed in terms of:

   a. availability ___ Yes ___ No
   b. accessibility ___ Yes ___ No
   c. cost ___ Yes ___ No

5. If your response to either 4a or 4b is Yes, please comment on the problem on a separate sheet of paper and attach hereto.

Appendix C

Nursing Home Proposals

1. Provide the current patient census at the facility by payer source in the table below.
Date of Census ___/___/___, Licensed bed capacity_____.

Payor	Number of Patients	Percent of Total
Medicaid		%
Medicare		%
Private Pay		%
Veterans		%
Other: (specify_____)		%
TOTAL:		**100%**

2. Please complete the following Medicaid per diem worksheet for the facility.

	COSTS		REIMBURSEMENT		MAXIMUM RATE	
Expense	**Current FY 20__**	**First FY 20___ Project Approved (proposed)**	**Current FY 20__**	**First FY 20___ Project Approved (proposed)**	**Current FY 20__**	**First FY 20___ Project Approved (proposed)**
Direct Labor						
Fair Rental						
Management						
All Others						
Pass Through Items						
TOTAL:						

Appendix C (Continues)

3. Complete the following itemization of projected utilization and net patient revenue for the first full operating year.

Payors	Implemented	Not Implemented	Incremental Difference
MEDICAID			
Per Diem Revenue			
Patient Days			
Total Revenue			
MEDICARE			
Per Diem Revenue			
Patient Days			
Total Revenue			
COMMERCIAL			
Per Diem Revenue			
Patient Days			
Total Revenue			
PRIVATE PAY			
Per Diem Revenue			
Patient Days			
Total Revenue			
VETERANS			
Per Diem Revenue			
Patient Days			
Total Revenue			
Other _____			
Per Diem Revenue			
Patient Days			
Total Revenue			
TOTAL PATIENT REVENUE			
TOTAL PATIENT DAYS			

Appendix D

All certificate of need applications which propose the construction, building, renovation, replacement, or alteration of the physical plant of a health care facility must include this appendix and provide the following requested information on a separate piece of paper:

Name of Applicant: _____

1. A description of the contemplated construction and schematic drawings of the proposal, in sufficient detail.

2. Describe all the alternatives to construction which were considered in planning this proposal and explain why these alternatives were rejected.

3. Attach evidence of site control, a fee simple, or such other estate or interest in the site including necessary easements and rights of way sufficient to assure use and possession for the purpose of the construction of the project.

4. If zoning approval is required as part of this proposal, attach evidence of application for zoning approval.

5. If this proposal involves new construction or expansion of patient occupancy, attach evidence from the appropriate state and/or municipal authority of an approved plan for water supply and sewage disposal.

6. Provide an estimated date of contract award for this construction project, assuming approval within a 120-day cycle.

7. Assuming this proposal is approved, provide an estimated date (month/year) that the service will be actually offered or a change in service will be implemented.

- If this service will be phased in, describe what will be done in each phase.

8. Describe the arrangements that have been made for architectural services, including the name and address of the architect.

9. If the construction described herein corrects any fire and life safety, Joint Commission on Accreditation of Healthcare Organizations (JCAHO), U.S. Department of Health and Human Services (DHHS) or other code compliance problems, include specific reference to the code(s). For each code deficiency, provide a complete description of the deficiency and the corrective action being proposed, including considerations of alternatives such as seeking waivers, variances or equivalencies.

10. Provide assurance and/or evidence of compliance with all other applicable federal, state and municipal fire, safety, use, occupancy, or other health facility licensure requirements.

11. Complete the change in space form attached hereto.

Change in Space Form Instructions

The purpose of this form is to identify the major effects of your proposal on the amount, configuration and use of space in your facility.

Column 1
Column 1 is used to identifying discrete units of space within your facility, which will be affected by this proposal. Enter in Column 1 each discrete service (or type of bed) or department, which as a result of this proposal is:

a.) to utilize newly constructed space
b.) to utilize renovated or modernized space
c.) to vacate space scheduled for demolition

In each of the Columns 3, 4, and 5, you are requested to disaggregate the construction, renovation and demolition components of this proposal by service or department. In each instance, it is essential that the total amount of space involved in new construction, renovation or demolition be totally allocated to these discrete services or departments listed in Column 1.

Column 2
For each service or department listed in Column 1, enter in this column the total amount of space assigned to that service or department at all locations in your facility whether or not the locations are involved in this proposal.

Column 3
For each service or department, please fill in the amount of space which that service or department is to occupy in proposed new construction. The figures in Column 3 should sum to the total amount of space of new construction in this proposal.

Column 4
For each service or department, please fill in the amount of space, which that service or department is to occupy in space to be modernized or renovated. The figures in column 4 should sum to the total amount of space of renovation and modernization in this proposal.

Column 5
For each service or department fill in the amount of currently occupied space which is proposed to be demolished. The figures in Column 5 should sum to the total amount of space of demolition specified in this proposal.

Column 6
For each service or department entered in Column 1, enter in this column the total amount of space which will, upon completion of this project, be assigned to that service or department at all locations in your facility whether or not the locations are involved in this proposal.

Column 7
Subtract from the amount of space shown in Column 6 the amount shown in Column 2. Show an increase or decrease in the amount of space.

Change in Space Form

Please identify and provide a definition for the method used for measuring the space (i.e. gross square footage, net square footage, etc.):

_____

_____

_____

_____

1. Service or Department Name	2. Current Space Amount	3. New Construction Space Amount	4. Renovation Space Amount	5. Amount of Space Currently Occupied to be Demolished	6. Proposed Space Amount	7. Change [(6)-(2)]
TOTAL:						

Appendix E

Acquisition of Health Care Equipment Valued in Excess of $1,000,000

Complete separate copies of this appendix for each piece of such equipment contained in this application.*

Name of Applicant: _____

1. Type of Equipment: _____

2. Name of Manufacturer: _____

3. Model Number: _____

4. Cost of Equipment: _____

5. Name and Address of Vendor: _____

6. Describe the clinical applications for which this equipment will be used.

7. Identify at least two similar makes or models of equipment which were considered for acquisition, and state your reasons for rejecting them in favor of this equipment. In your discussion include comparisons of capital costs, operating cost, maintenance considerations, etc. and any other factors which guided the decision-making.

8. For each piece of existing equipment to be replaced by this equipment, provide its date of acquisition, expected salvage value, remaining useful life, actual utilization for the last three years, and the ways in which the replacement equipment will be used or disposed of subsequent to acquisition of the replacement equipment.

9. Please state below the number of new full-time equivalent personnel by job category whom you will hire in order to operate this equipment.

Job Category	Number of FTE's	Payroll Expense

10. Please describe below your anticipated utilization for this equipment, both hours of operation and numbers of procedures, tests, etc. for each of the three fiscal years following acquisition of this equipment.

Fiscal Year	20___	20___	20__
Hours of Operation			
Number of Procedures			

* Information must be provided in response to these questions even if a specific vendor has not been agreed upon.

Appendix F

Debt Financing

Applicants contemplating the incurrence of a financial obligation for full or partial funding of a certificate of need proposal must complete and submit this appendix.

Name of Applicant: _____

1. Describe the proposed debt by completing the following:
   a.) type of debt contemplated: _____
   b.) term (months or years): _____
   c.) principal amount borrowed _____
   d.) probable interest rate _____
   e.) points, discounts, origination fees _____
   f.) compensating balance or reserve fund _____
   g.) likely security _____
   h.) disposition of property (if a lease is revoked) _____
   i.) prepayment penalties or call features _____
   j.) front-end costs (e.g. underwriting spread, feasibility study, legal and printing expense, points etc.) _____
   k.) debt service reserve fund _____

2. Compare this method of financing with at least two alternative methods including tax-exempt bond or notes. The comparison should be framed in terms of availability, interest rate, term, equity participation, front-end costs, security, prepayment provision and other relevant considerations.

3. If this proposal involves refinancing of existing debt, please indicate the original principal, the current balance, the interest rate, the years remaining on the debt and a justification for the refinancing contemplated.

4. Present evidence justifying the refinancing in Question 3. Such evidence should show quantitatively that the net present cost of refinancing is less than that of the existing debt, or it should show that this project cannot be financed without refinancing existing debt.

5. If lease financing for this proposal is contemplated, please compare the advantages and disadvantages of a lease versus the option of purchase. Please make the comparison using the following criteria: term of lease, annual lease payments, salvage value of equipment at lease termination, purchase options, value of insurance and purchase options contained in the lease, discounted cash flows under both lease and purchase arrangements, and the discount rate.

6. Present a debt service schedule for the chosen method of financing, which clearly indicates the total amount borrowed and the total amount repaid per year. Of the amount repaid per year, the total dollars applied to principal and total dollars applied to interest must be shown.

7. Please include herewith an annual analysis of your facility's cash flow for the period between approval of the application and the third year after full implementation of the project.